IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 6, 2012

Chris Roth, Administrator
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Roth:

On **March 23, 2012**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005372

Allegation #1: The facility failed to appropriately assess and monitor patients.

Finding #1: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Staff and patients were interviewed. Medical records and incident reports were reviewed.

Six closed outpatient surgery records, four current inpatient records, and ten closed inpatient records were reviewed. All records contained documentation of routine assessments, monitoring, and symptom management.

One record reviewed documented a 49 year old male admitted to the facility 11/10/11 and discharged 11/24/11. On 11/29/11, the patient was readmitted and ultimately discharged on 12/13/11. The patient was originally admitted for abdominal discomfort and diagnosed with advanced stage esophageal cancer with metastasis through the gastrointestinal tract. The patient was readmitted for worsening symptoms related to the cancer. Additionally, the patient had a history of quadriplegia with partial function in his upper extremities, as well as sleep apnea, for which CPAP (continuous positive air pressure) was used.

An order for respiratory therapy (RT) to assess and to use the patient's own CPAP machine was written on admission. Later that day, RT screened the patient and documented the CPAP settings in the medical record. Throughout his first admission, documentation indicated the CPAP was being used at night as ordered by the physician. During the second admission, the patient was documented as having an NG (nasogastro) tube present, which precluded the use of the CPAP as noted by the physician on 11/29/11 in the progress notes. When the patient's NG tube was discontinued, a physician order initiated the use of the patient's own CPAP. The CPAP was documented in use once the NG tube was discontinued.

Two current patients were interviewed who used CPAP machines at night. Both stated neither they, nor staff, had problems related to their CPAP machine.

One 6th floor nurse was interviewed 3/16/12 regarding CPAP machines. She stated that when a patient brought in a CPAP from home, RT was called to check the CPAP and see if the settings were correct. The nurse stated if she ever needed help with a CPAP machine, RT was called or the patient was asked if it was their own machine.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each stated they felt they were well cared for. Each stated that all their symptoms were assessed, monitored, and managed in a timely fashion.

It could not be determined facility staff failed to appropriately assess and monitor patients.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to discuss discharge plans with patients and/or families.

Finding #2: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Staff and patients were interviewed. Medical records were reviewed.

Six closed outpatient surgery records, four current inpatient records, and ten closed inpatient records were reviewed. All records reviewed contained documentation of physician orders for discharge, discharge criteria being met, discharge assessments, and provided education.

One record reviewed documented a 49 year old male who was admitted to the facility for abdominal pain. He had a history of quadriplegia, and a new diagnosis of esophageal cancer. Physician progress notes documented multiple conversations with the patient and his family regarding his discharge disposition. A hospice Registered Nurse (RN) visited the patient on 11/21/11 to assess for discharge. On 11/23/11, the patient was documented as refusing hospice

care at that time and wanting to move forward with a skilled nursing/rehabilitation facility. On 11/24/11, case management documented the patient and spouse verbalized agreement to the discharge plan and that paperwork was signed. This was again documented by the discharging RN.

The above patient's discharging case manager was interviewed on 3/20/12. She stated she did not specifically remember this patient and his family, but it was her practice to meet with patients and families the day of discharge to explain any final information, like transportation coordination. She stated pertinent information, like physician orders, physician progress notes, discharge orders, medication administration records, and legal documents such as POST (Physician Orders for Scope of Treatment) forms always get sent to the receiving facility as it was those forms that alert the facility to the patient's pending discharge. She stated it was the receiving facility's job to review the patient's information and make a final determination if they can properly care for the patient's needs. She also stated that during the initial discussions with patients and families needing placement assistance, the case manager gives the patient/family a list of facilities to decide from. She stated a facility list could be narrowed to specific areas, insurance limitations, and/or if the facility cared for certain medical needs.

The RN caring for the patient on the day of discharge was interviewed 3/20/12. She stated she remembered caring for the patient on 3/24/11 and that he was alert, answering questions and conversing appropriately with both providers and family. She stated she spoke with the patient and he expressed a desire to wait another day to discharge as it was a holiday. The RN stated she spoke with the physician who said the patient was medically stable to discharge that day. The RN reported she returned to talk with the patient and the patient's wife had arrived. The RN stated the wife said it was okay to transfer that day and the patient then agreed to go. The RN stated she remembered the patient's wife took belongings to her car, but cannot remember for sure if the wife had returned by the time the ambulance arrived to transport the patient to the receiving facility. The RN stated the patient and his wife both knew the patient was discharging that day.

Two current patients were interviewed on the day they were being discharged. Both stated they and their family were involved in the discharge process and did not express any concerns related to the process.

It could not be determined the facility failed to discuss discharge plans with patients and/or families. A complaint was filed regarding care provided in the receiving facility based on the investigation.

Conclusion: Unsubstantiated. Lack of sufficient evidence. Referral to the appropriate agency.

Allegation #3: The facility failed to follow infection control standards.

Finding #3: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Observations were conducted. Staff and patients were interviewed. Housekeeping records and grievance documentation were reviewed.

Fifteen grievances were reviewed, one of which included an allegation of a staff member not performing hand hygiene or appropriately cleaning a medication vial prior to accessing it. Documentation of the response to the grievance included one-on-one education and follow-up with the specific staff member by the Manager of the Cardiac Care and Telemetry Units.

Observations occurred on the 4th floor on 3/15/12 from 1:45 PM to 3:15 PM, and on 3/16/12 from 8:45 AM to 10:30 AM and 1:15 PM to 3:15 PM. Observations also occurred on the 6th floor on 3/15/12 from 2:15 PM to 3:15 PM and on 3/16/12 from 9:10 AM to 10:00 AM.

Staff were observed to wash hands appropriately on entering and exiting rooms, before and after patient contact, and as needed. Clean rooms were observed and recently vacated rooms were being cleaned by housekeeping staff. Nursing and respiratory therapy staff were observed passing medications and assessing patients. All staff observed washed their hands and prepared medications appropriately.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each stated staff performed hand hygiene.

It was determined one staff failed to follow infection control standards in past instances. However, current practice indicated infection control standards were being followed. Therefore, no deficiencies were cited.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #4: The facility failed to provide personal cares.

Finding #4: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Observation was conducted. Patients and staff were interviewed. Medical records were reviewed.

Four current inpatient records and ten closed inpatient records were reviewed. All records contained documentation of personal cares being provided daily and as needed.

One record documented a 49 year old male admitted to the facility for abdominal pain. He had a history of quadriplegia, and a new diagnosis of esophageal cancer. Personal hygiene cares were attended to daily. The patient was documented as shaved once on 11/12/11, during his first admission. Other personal cares, like baths, oral care, and toileting needs were provided or offered daily and as needed. Repositioning and an air mattress and floating heels were used to prevent skin breakdown.

Fourteen current inpatient were interviewed. Each stated personal cares were offered daily. One patient interviewed stated he was offered a shave, but refused it.

Observations occurred on the 4th floor on 3/15/12 from 1:45 PM to 3:15 PM, and on 3/16/12 from 8:45 AM to 10:30 AM and 1:15 PM to 3:15 PM. Observations also occurred on the 6th floor on 3/15/12 from 2:15 PM to 3:15 PM and on 3/16/12 from 9:10 AM to 10:00 AM. Patients were observed to be cleaned and attended to by staff.

It could not be determined patients were not provided personal hygiene cares.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The facility failed to provide care per physicians' orders.

Finding #5: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Medical records were reviewed. Patients and staff were interviewed.

Four current inpatient records and ten closed inpatient records were reviewed. 13 of 14 records contained documentation of cares provided per physician orders.

However, one record reviewed documented a 49 year old male admitted to the facility 11/10/11 and discharged 11/24/11. On 11/29/11, the patient was readmitted and ultimately discharged on 12/13/11. The patient was originally admitted for abdominal discomfort, where facility staff determined the patient had an advanced stage of esophageal cancer with metastasis through the gastrointestinal tract. After the first admission, the patient was readmitted for worsening symptoms related to the cancer. Additionally, the patient had a history of quadriplegia with partial function in his upper extremities, as well as sleep apnea, for which CPAP was used.

The patient had a paracentesis abdominal drain placed 11/17/11. On 11/28/11, the patient was brought into the Emergency Department (ED) and his abdominal drain was attached to low intermittent suction. When the patient was admitted from the ED to the 6th floor on 11/29/11, there was no transition order for the suction to be discontinued. At 4:50 AM on 11/29/11, the admitting physician ordered the abdominal drain suction to be discontinued. However, nursing

documentation showed the suction was not discontinued until 8:43 PM on 11/29/11.

An NG tube was placed in the ED on 11/28/11 and was ordered to be a low intermittent suction when admitted to the 6th floor on 11/29/11 at 4:50 AM. However, nursing documentation showed the NG tube was set at low continuous suction until 8:43 PM on 11/29/11.

The patient had a Percutaneous Endoscopic Gastrostomy (PEG) tube placed 12/02/11 at the same time a paracentesis was done. When the patient returned to the 6th floor at 6:45 PM, the PEG tube was ordered to be attached to suction on low intermittent suction. However, the suction was not applied for an hour, when it was brought the attention of nursing staff by the patient's family member.

A clinical supervisor reviewed the record and stated she agreed the drains were not attached to suction as ordered by the physician.

Between 3/15/12 and 3/21/12, fourteen current inpatients were interviewed regarding their care. All interviewed patients stated they had no concerns with their care.

Since one record showed care did not follow physician's orders, the allegation was substantiated. However, current record review and patient interview did not find any similar issues and therefore, no deficiencies were cited.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #6: The facility failed to thoroughly investigate and respond to grievances.

Finding #6: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Documentation for fifteen grievances, medical records, and event reports were reviewed. Staff and patients were interviewed.

Documentation for fifteen grievances was reviewed. All of the grievance documentation contained information related to the investigation and resolution of grievances. Acknowledgement letters and final notices were provided to patients/families in accordance with hospital policy. The documentation present supported the hospital's investigation into the grievances presented to them and the education provided to staff, or changes made within hospital protocol, as a result of the investigations.

One grievance reviewed contained documentation of a patient being discharged to another facility without notifying the family first. The grievance also included concerns related to patient cares not being provided, nutritional needs not being met, staff not being competent or

professional, poor pain management, the patient being found malpositioned in bed, and staff not following infection control standards. The grievance came from the patient's family members via phone, face to face conversation, and a letter to the facility. Grievance documentation indicated that several people in various departments spoke with the patient's family. A written response regarding the steps taken to investigate the grievance and the response of the grievance was sent to the patient in accordance with hospital policy.

A physician progress note dated 12/03/11 documented the patient was found by his family out of position in bed and in pain. The patient had returned from a procedure requiring conscious sedation and nursing staff had not restarted the patient's pain pump. The patient was transfer to a different area of the facility per patient and family request.

An event report was filed 12/03/11 related to the patient being found malpositioned and in pain. Concerns related to the event were addressed at the time the concerns were brought to the attention of staff. Each concern was documented as addressed to the satisfaction of the family. Concerns addressed included the request to move the patient off the air bed, nutritional needs not met, NG tube interfering with the patient using his CPAP at night, and the pain pump not being restarted. The charge nurse on 12/03/11 explained the purpose of the air bed in preventing further skin breakdown, the use of total parenteral nutrition and fluids instead of a percutaneous endoscopic gastrostomy (PEG) tube because of the ascites and the way tumors steal nutrients, the decision by the physician to discontinue the NG tube per family request, and the nurse's assessment that the patient was still somnolent from the procedure.

A Clinical Specialist for the Office of Patient Experience was interviewed on 3/23/12. She explained the process upon receipt of a grievance. She stated she initially notified department leadership of the unexpected event. She reviewed the medical record, spoke with physicians and staff involved with the patient. She stated she spoke directly with the patient or family. She stated after a full review, if warranted, the grievance would be forwarded to additional leadership staff for additional processing and review (such as completion of a root cause analysis). Otherwise the patient/family received a written response from Patient Relations services. She stated this process was now completed in the computer and enabled faster and more direct communication between departments to facilitate the investigation. In addition, she stated that Patient Relations staff and Patient Safety staff meet every couple of weeks to discuss collaborative cases.

Fourteen current patients were interviewed between 3/15/12 and 3/21/12. Each patient indicated they were aware of the process to voice a concern and felt comfortable addressing concerns with staff. None of the patients interviewed had any concerns that had not been addressed.

It could not be determined that the facility failed to thoroughly investigate and respond to

grievances.

Conclusion: Unsubstantiated: Lack of sufficient evidence

Allegation #7: The facility failed to meet nutritional needs of patients.

Finding #7: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Patients and staff were interviewed. Medical records were reviewed.

Four current inpatient records and ten closed inpatient records were reviewed. All records contained documentation of nutrition screens and consults on admission, per physician order, and per hospital policy.

A Registered Dietician (RD) was interviewed on 3/21/12 regarding nutritional screening in the facility. She stated that on admission, every patient has a nutrition screen documented by the nurse, which results in a score. She stated any score 2 or higher triggers an automatic nutrition consult. She stated all patients' diet orders were reviewed on day 6 of their stay and if they were NPO (nothing by mouth) at that time, then they received a nutrition consult. If a patient had not already received a nutritional consult by day 8 of their stay, then they were seen that day by a dietician.

One record reviewed documented a 49 year old male admitted to the facility 11/10/11 and discharged 11/24/11. On 11/29/11, the patient was readmitted and ultimately discharged on 12/13/11. The patient was originally admitted for abdominal discomfort, where facility staff determined the patient had an advanced stage of esophageal cancer with metastasis through the gastrointestinal tract. After the first admission, the patient was readmitted for worsening symptoms related to the cancer. Additionally, the patient had a history of quadriplegia with partial function in his upper extremities, as well as sleep apnea, for which CPAP was used.

When the patient was admitted 11/10/11, the admission assessment nutrition screen did not document a need for a dietary consult. However, the patient was seen by dietary services on 11/19/11 for the "8 day" screen. During his first stay, the patient was NPO (nothing by mouth) prior to an EGD (esophagogastroduodenoscopy) and colonoscopy. During this time, the patient was receiving IV (intravenous) fluids. Once those procedures were done, the physician ordered a general diet as tolerated by the patient. On 11/12/11, the physician noted the patient was eating a hamburger. IV fluids were then stopped as the patient was tolerating oral intake.

On the 11/29/11 admission assessment, the nutrition screen triggered a nutrition screen by dietary, which was done 11/30/11. The patient was ordered to be NPO due to constipation being treated by an NG tube. IV fluids were started on admit and, per dietary recommendations,

Procalamine (peripheral parenteral nutrition) was started 12/01/11.

Throughout both his stays, the patient was treated with bowel medications. Radiological screens and physician progress notes documented the patient had constipation related to carcinomatosis (widespread dissemination of tumors). EGD and colonoscopy found numerous lesions in the gastrointestinal tract. These tumors led to the bowels moving more slowly and absorbing less, which resulted in the patient needing aggressive bowel care to treat resultant constipation.

It could not be determined the facility failed to meet the nutritional needs of patients.

Conclusion: Unsubstantiated: Lack of sufficient evidence.

Allegation #8: The facility failed to ensure nurses followed standards of practice related to peripheral intravenous access.

Finding #8: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12.

One record reviewed documented a 49 year old male admitted to the facility 11/10/11 and discharged 11/24/11. On 11/29/11, the patient was readmitted and ultimately discharged on 12/13/11. The patient was originally admitted for abdominal discomfort, where facility staff determined the patient had an advanced stage of esophageal cancer with metastasis through the gastrointestinal tract. After the first admission, the patient was readmitted for worsening symptoms related to the cancer. Additionally, the patient had a history of quadriplegia with partial function in his upper extremities, as well as sleep apnea, for which CPAP was used.

A peripheral IV line was placed 11/14/11 and was not documented as being removed until 11/22/11, 8 days later. Nursing documentation showed the IV line remained in place per physician order, however, no corresponding order could be found.

The facility's policy, titled "INTRAVENOUS THERAPY - IV Therapy Appendix A," reviewed/revised 8/22/11, stated a peripheral IV needs to be restarted every four days.

On 3/21/12, the patient's record was reviewed by a clinical supervisor on the telemetry unit. He stated he did see the nursing note and the charge RN's night audit of IV lines, which both stated the physician gave an order to leave the IV line in. However, he stated he did not see a written order to leave the IV line in place past four days, which he stated did not follow facility policy.

Nursing staff were interviewed on 3/15/12 and 3/16/12 regarding their understanding of the length of time a peripheral IV line could remain in place before it needed to be changed. All staff

stated an IV line could not be in longer than four days without a physician's order.

Four of four current inpatient records documented peripheral IV lines not exceeding the four days without being changed.

Although nursing did not monitor and change an IV line per policy, or monitor a patient for safe positioning in one closed record, current practice reflected appropriate monitoring and assessments of patients. Therefore, no deficiencies were cited.

Conclusion: Substantiated: No deficiencies related to the allegation are cited.

Allegation #9: The facility failed to manage patients' pain.

Finding #9: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Staff and patients were interviewed. Medical records and incident reports were reviewed.

Six closed outpatient surgery records, four current inpatient records, and ten closed inpatient records were reviewed. All records contained documentation of routine assessments, monitoring, and symptom management.

One record reviewed documented a 49 year old male admitted to the facility 11/10/11 and discharged 11/24/11. On 11/29/11, the patient was readmitted and ultimately discharged on 12/13/11. The patient was originally admitted for abdominal discomfort, where facility staff determined the patient had an advanced stage of esophageal cancer with metastasis through the gastrointestinal tract. After the first admission, the patient was readmitted for worsening symptoms related to the cancer. Additionally, the patient had a history of quadriplegia with partial function in his upper extremities, as well as sleep apnea, for which CPAP was used.

During the patient's second admission, palliative services managed the pain treatment. Throughout this admission, the patient was being medicated with IV (intravenous) pain medications. On 11/30/11, a PCA (patient controlled analgesia) was ordered. The PCA allowed the patient to receive continuous narcotics and give himself as needed boluses of medications. On 12/02/11, the patient returned from a procedure that required conscious sedation. Documentation recorded that the patient's family found the patient in an unsafe position and in pain and the PCA off an hour after the procedure. The physician documented a progress note related to the event on 12/02/11 related to concerns by the patient and family of being left and unmonitored in a painful, unsafe position in bed. Previously, the patient had repeatedly asked to have a regular bed instead of an air mattress. However, as the patient was developing a pressure ulcer, facility staff did not feel that a regular mattress was an option.

An event report for the above noted incident was reviewed. It documented the PCA had not been reconnected as the patient was still somnolent. The patient's and family's concerns were documented on 12/03/11 as addressed to the satisfaction of the patient and family.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each stated they felt they were well cared for. Each stated that all their symptoms were assessed, monitored, and managed in a timely fashion.

It was determined the facility failed to manage a patient's pain in the past. However, current patients reported their pain being well managed. Therefore, no deficiencies were cited.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 6, 2012

Chris Roth, Administrator
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Roth:

On **March 23, 2012**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005422

Allegation #1: A patient was admitted to an unclean room and potentially exposed to an infectious disease.

Finding #1: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Observations were conducted. Staff and patients were interviewed. Housekeeping records and grievance documentation were reviewed.

Observations occurred on the 4th floor on 3/15/12 from 1:45 PM to 3:15 PM, and on 3/16/12 from 8:45 AM to 10:30 AM and 1:15 PM to 3:15 PM. Housekeeping staff were observed on the floors cleaning rooms of discharged patients and performing routine housekeeping. Staff were observed to respond to specific requests to clean after spills, etc. Rooms were observed to have clean linen, empty garbage cans, and clean floors.

Observations were conducted on the 6th floor on 3/15/12 from 2:15 PM to 3:15 PM and on 3/16/12 from 9:10 AM to 10:00 AM. At 9:15 AM on 3/16/12, a drop of blood was noted to be on a patient's blanket by the nurse. The nurse was observed to retrieve a new blanket and was assisted by the Certified Assistant Personnel (CAP) to replace the soiled blanket. Rooms were

observed to have clean floors and empty trash cans.

Grievance documentation was reviewed for fifteen filed grievances. One grievance reviewed contained documentation of an event concerning a patient being admitted into an unclean room and potentially exposed to infectious diseases. The initial report, documented by a nurse, indicated the patient and family reported "snot" on the call light. The nurse documented a CAP stated she brought sanitary wipes to the room and that the CAP stated she "did not see anything on the call light or on the wipes after the pt (patient) was done using them."

The CAP referenced in the grievance documentation was interviewed on 3/20/12 at 2:40 PM. She stated she did not recall the incident but that if she were presented with the same scenario she would evaluate the soiled area and report the issue to the nurse. She stated she would not provide hand wipes to the patient or family and would not expect them to clean up anything. She explained the process of admitting a patient. She stated she was notified of the room assignment, brought supplies to the room, and ensured the room was clean. She stated as part of this process she examined the bed rails because she had to prepare the bed to weigh the patient.

A 6th floor housekeeper was interviewed on 3/15/12. She explained the use of the "HOUSEKEEPING LOG" to track when rooms were cleaned. She stated staff documented the time the patient was discharged. Then the time the housekeeper began and completed the cleaning was documented. She stated the housekeeper initialed that the room was clean. She stated if it was an isolation room, two sets of initials were required to verify the room was cleaned.

The "HOUSEKEEPING LOG" for the date of admission of the patient who complained of a dirty room was reviewed. The room was documented as an isolation room that was cleaned by 1:55 PM and signed by two staff members. The medical record indicated the discharged patient had tested negative for the infectious disease responsible for the demarcation on the HOUSEKEEPING LOG," and did not require isolation. However, housekeeping staff cleaned the room as if it was an isolation room.

The Infection Prevention Practitioner was interviewed on 3/21/12 at 4:15 PM. She stated she was not aware that anyone specifically visualized the soiled area. However, the facility responded as if it were contaminated and posed an infection control risk. She stated she reviewed the medical history and lab reports of the person in the room prior to the patient and noted the previous patient was being treated for pneumonia (as was the patient involved in the grievance). She stated that the reason the room was documented in the "HOUSEKEEPING LOG" as an isolation room was because the patient had been tested for an infectious disease. The Infection Prevention Practitioner stated the microbiology reports were reviewed and the patient tested negative for the infectious disease and therefore no longer required isolation

precautions. She stated she spoke with an Infectious Disease physician who confirmed that based on the diagnosis of the patient who resided in the room prior, and the description of the events surrounding the discovery of the substance, there was no risk for exposure or cross-contamination. She stated as a result of this event, she met with the unit director of the floor and the housekeeping manager. She stated staff were re-educated on the importance of cleaning the rooms, especially the high-touch areas such as bed rails and call lights.

The Administrative Supervisor who responded to the incident was interviewed on 3/21/12. She stated she believed hospital staff had cleaned up the substance, but could not be certain. She stated she offered to move the patient to a different room but this offer was declined.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each stated that they were admitted into a clean room, that staff routinely cleaned their room and changed linens as appropriate. One patient stated that staff were very responsive to her request to change a room, not based on cleanliness but because the patient felt the room was too small. None of the patients expressed any concerns related to infection control issues while in the hospital.

It was determined a patient was admitted into an unclean room, however, the patient was not exposed to an infectious disease. Observations and interviewed determined sanitation was not a current concern and no deficiencies were cited.

Conclusion: Substantiated. no deficencies related to the allegation are cited.

Allegation #2: Nursing staff failed to provide adequate pain management.

Finding #2: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Patients were interviewed and medical records were reviewed.

Six closed outpatient surgery records, four current inpatient records, and ten closed inpatient records were reviewed. All records contained documentation of nursing assessments of pain, administration of pain medications when appropriate, and follow up evaluation for effectiveness of the pain medication.

One medical record contained documentation of a female admitted to the hospital for treatment of pneumonia. Nursing staff documented assessment of pain throughout the hospital admission. Pain was typically rated 7-10 out of 10. Medication was administered and a follow up assessment was completed between 30 minutes to 1 hour after administration. With the exception of the first night, pain relief was rated 1-4 out of ten after medication administration. On the first night of admission, pain remained at an 8 out of 10 and additional pain relief medication was administered.

Fourteen current inpatients, and three patients discharged from outpatient surgery were interviewed. All patients stated that nursing staff routinely monitored pain levels and administered pain medications in a timely manner in accordance with physicians' orders. One patient stated that she was having significant difficulty with pain management, but physicians and staff were working hard to help her achieve adequate pain control.

It could not be determined that nursing staff failed to provide adequate pain management.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Staff did not maintain patient confidentiality.

Finding #3: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Observations were conducted and patients and staff were interviewed.

Observations occurred on the 4th floor on 3/15/12 from 1:45 PM to 3:15 PM, and on 3/16/12 from 8:45 AM to 10:30 AM and 1:15 PM to 3:15 PM. Observations were conducted on the 6th floor on 3/15/12 from 2:15 PM to 3:15 PM and on 3/16/12 from 9:10 AM to 10:00 AM. Staff were observed, and heard, utilizing companion phones to communicate with each other. Staff identified patients by room number, if at all, and no personal information was discussed over the phone within earshot of patients or visitors.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each stated staff maintained patient confidentiality. Several patients acknowledged that staff answered the companion phone while in the room, but would often ask to step out to take the call and never revealed any personal information about other patients in their presence.

It could not be determined that staff did not maintain patient confidentiality.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility failed to thoroughly investigate and respond to grievances.

Finding #4: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Documentation for fifteen grievances, medical records, and event reports were reviewed. Staff and patients were interviewed.

Documentation for fifteen grievances was reviewed. All of the grievance documentation contained information related to the investigation and resolution of grievances. Acknowledgement letters and final notices were provided to patients/families in accordance with

hospital policy. The documentation present supported the hospital's investigation into the grievances presented to them and the education provided to staff, or changes made within hospital protocol, as a result of the investigations.

One grievance contained documentation of an event concerning a patient being admitted into an unclean room and potentially exposed to infectious diseases. The initial report, documented by a nurse, indicated the patient and family reported "snot" on the call light. Grievance documentation indicated the Clinical Patient Relations Specialist spoke with the patient's spouse regarding the above, and additional concerns including placement of the identification band upon admission, lack of interdepartmental communication, lack of attention to changing patient linens, and lack of pain management. A written response regarding the steps taken to investigate the grievance and the response of the grievance was sent to the patient in accordance with hospital policy.

A Clinical Specialist for the Office of Patient Experience was interviewed on 3/19/12. She explained that the above issues were addressed by the Supervisor of Patient Registration, the Manager of Housekeeping, the Director of the 6th Floor Medical/Surgical Unit, the Director of Nursing Administration, and the Infection Prevention Department.

The Infection Prevention Practitioner was interviewed on 3/21/12. She stated she was not aware that anyone specifically visualized the soiled area. However, the facility responded as if it were contaminated and posed an infection control risk. She stated she reviewed the medical history and lab reports, including microbiology reports from the lab, of the person in the room prior to the patient and noted the patient was being treated for pneumonia, just like the complainant. She stated she additionally spoke with an Infectious Disease physician who confirmed that based on the diagnosis of the patient who resided in the room prior, and the description of the events surrounding the discovery of the substance, there was no risk for exposure or cross-contamination. She stated as a result of this event, she met with the unit director of the floor and the housekeeping manager. She stated staff were re-educated on the importance of cleaning the rooms, especially the high-touch areas such as bed rails and call lights.

A Clinical Specialist for the Office of Patient Experience was interviewed on 3/23/12. She explained the process upon receipt of a grievance. She stated she initially notified department leadership of the unexpected event. She reviewed the medical record, spoke with physicians and staff involved with the patient. She stated she spoke directly with the patient or family. She stated after a full review, if warranted, the grievance would be forwarded to additional leadership staff for additional processing and review (such as completion of a root cause analysis). Otherwise the patient/family received a written response from Patient Relations services. She stated this process was now completed in the computer and enabled faster and more direct communication between departments to facilitate the investigation. In addition, she stated that

Patient Relations staff and Patient Safety staff meet every couple of weeks to discuss collaborative cases.

Fourteen current patients were interviewed between 3/15/12 and 3/21/12. Each patient indicated they were aware of the process to voice a concern and felt comfortable addressing concerns with staff. None of the patients interviewed had any concerns that had not been addressed.

It could not be determined that the facility failed to thoroughly investigate and respond to grievances.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The failure to document a breathing treatment resulted in administration of a second breathing treatment causing pain and suffering.

Finding #5: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Patients and staff were interviewed and medical records were reviewed. Observations were conducted.

Observations occurred on the 4th floor on 3/15/12 from 1:45 PM to 3:15 PM, and on 3/16/12 from 8:45 AM to 10:30 AM and 1:15 PM to 3:15 PM. Observations were conducted on the 6th floor on 3/15/12 from 2:15 PM to 3:15 PM and on 3/16/12 from 9:10 AM to 10:00 AM. Medication and breathing treatment administration was observed on several occasions during the above time frames. In each instance staff were observed to scan the medication and scan the patient and confirm the medication administration in the computer system.

Six closed outpatient surgery records, four current inpatient records, and ten closed inpatient records were reviewed. All records contained documentation of breathing treatments and exercises in accordance with physician's orders.

One medical record contained documentation of a female admitted to the hospital for treatment of pneumonia. Her medical record contained orders for breathing treatments every four hours beginning the morning after her admission for 24 hours, then four times a day after that. In addition, a breathing exercise called "Positive Expiratory Pressure Therapy" was ordered four times a day. The medication administration record and notes from respiratory therapy assessments indicated that both the breathing treatments and the breathing exercises were completed as ordered. Documentation in the respiratory therapy assessments indicted that the breathing exercises were well tolerated and that on the morning of discharge the patient was able to complete the exercises independently.

A Registered Nurse (RN) on the 4th floor was observed and interviewed during medication administration on 3/16/12. She explained that the medication administration record is completely electronic. She was observed to review the medication order in the computer, scan the medications to be administered, then scan the patient identification band. She stated that if the medication and/or patient identification were not correct, the system would alarm. She stated once you had scanned the medication and the patient identification band the computer would post a warning if you attempted to exit without documenting completion of medication administration.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each was able to explain the process of scanning the medications and then scanning their identification bands prior to medication administration. Several patients received breathing treatment and/or breathing exercises and stated they did not have any issues with respiratory services and the provision of respiratory care.

A Respiratory Therapist from the 4th floor was observed on 3/16/12 completing an assessment and administering medications. She stated part of the shift report from therapist to therapist included when the last treatments were given. The Respiratory Therapist was observed assisting a patient with a breathing exercise. The patient was observed to request the exercise be discontinued and the Respiratory Therapist honored this request.

It could not be determined that patients received duplicate treatments as a result of inaccurate documentation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Patients were not appropriately identified prior to provision of care or treatments.

Finding #6: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Observations were conducted. Staff and patients were interviewed.

Observations occurred on the 4th floor on 3/15/12 from 1:45 PM to 3:15 PM, and on 3/16/12 from 8:45 AM to 10:30 AM and 1:15 PM to 3:15 PM. Observations were conducted on the 6th floor on 3/15/12 from 2:15 PM to 3:15 PM and on 3/16/12 from 9:10 AM to 10:00 AM. Staff were observed to verbally and visually (by reading the identification band) identify patients for medication administrations, transport to different locations in the hospital for diagnostic testing, and prior to blood draws.

Fourteen current inpatients were interviewed between 3/15/12 and 3/21/12. Each patient stated that staff routinely identified them prior to providing any care or treatment. Many of them stated

they were more comfortable with care because staff made such an effort to identify them to avoid errors.

The Manager of Medical Imaging was interviewed on 3/15/12. She explained that when patients needed to be transported from the medical floors to Medical Imaging, a Transporter (an individual who transports patients throughout the facility) was used. She stated that when the Transporter collected a patient they also brought the medical record with them. Once the patient was in Medical Imaging, the chart would be passed off to the appropriate Medical Imaging staff member who then verified the test to be completed (by visualizing the physician order) and correctly identifying the patient. She confirmed that testing would not be completed, if there was any question about the order, until the patient and the test had been clarified.

A Transporter for the hospital was interviewed on 3/15/12. She explained that each Transporter received a page with the patient name, room number, location to be transported to, and the mode of transportation required. She stated they would be notified if the patient was in isolation. She confirmed that upon collecting a patient for transport, the patient was properly identified and the medical record was obtained if needed. She stated for medical imaging procedures the medical record was transported with the patient and handed to Medical Imaging staff.

It could not be determined that patients were not appropriately identified prior to the provision of care.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 6, 2012

Chris Roth, Administrator
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Roth:

On **March 23, 2012**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005480

Allegation #1: Staff failed to assess and address a patient's shortness of breath, pain, and irregular heart rate prior to discharge.

Finding #1: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Staff and patients were interviewed. Medical records and policies were reviewed.

Six closed outpatient surgery records, four current inpatient records, and ten closed inpatient records were reviewed. Each record contained documentation of routine assessments, monitoring, and symptom management throughout the hospital stay.

The "Care of the Post-Anesthesia Patient" policy was reviewed. Each of the six outpatient surgery records contained documentation of monitoring, assessing, and treating patients in accordance with hospital policy.

One outpatient surgery record reviewed contained documentation of a 76 year old female admitted for overnight observation after her shoulder surgery. A pre-operative EKG

(electrocardiogram) was performed on 8/03/11, which showed the patient had an abnormal EKG but was deemed appropriate to proceed with surgery anyway. The patient was monitored by anesthesia services via EKG throughout the surgery. In the PACU (post-anesthesia care unit), cardiac rhythm monitoring showed an occasional irregular heart rate, which was consistent with the pre-operative EKG. On 8/04/11, the patient was admitted for overnight observation because of nausea, being difficult to arouse after anesthesia administration, and difficulty maintaining sufficient oxygen saturation levels on room air. On 8/05/11, the surgeon's progress note stated, "Feels much better." There was no indication in the medical record that the patient was experiencing shortness of breath or irregular heart rate prior to discharge. Documented pain assessments indicated pain was controlled with the use of oral pain medications, which the patient was going home on. Ten minutes prior to discharge, the patient was documented as having a pain score of 4 out of 10 and was given oral pain medication. The patient signed her discharge instructions.

The Accreditation Manager was interviewed on 3/23/12. She stated that a grievance had been submitted on behalf of this patient and the medical record had been the subject of a significant amount of review, by both nursing and physician staff. The Accreditation Manager stated that during the process of review it was determined that one way to improve the care provided in the PACU, and potentially impacting the type of observation needed following discharge from the PACU, was to re-educate staff regarding assessing and monitoring cardiac rhythm strips.

Fourteen current inpatients were interviewed. Three patients discharged from outpatient surgery were interviewed via telephone. All patients felt they had been well cared for. Each stated that all symptoms were assessed, monitored, and managed in a timely fashion and prior to discharge.

It could not be determined that staff failed to assess and address patient symptoms prior to discharge.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to thoroughly investigate and respond to grievances.

Finding #2: An unannounced complaint investigation survey was conducted from 3/15/12 through 3/23/12. Documentation for fifteen grievances, medical records, policies, and event reports were reviewed. Staff and patients were interviewed.

All of the grievance documentation contained information related to the investigation and resolution of grievances. Acknowledgement letters and final notices were provided to patients/families in accordance with hospital policy. The documentation present supported the hospital's investigation into the grievances presented to them and the education provided to staff,

or changes made within hospital protocol, as a result of the investigations.

One grievance documented concerns of a patient who had shoulder surgery and was admitted for overnight observation. Two days later the patient was evaluated in the Emergency Department and subsequently admitted for pneumonia, a small pneumothorax, and a cardiology work up. The Clinical Specialist for the Office of Patient Experience was interviewed on 3/23/12 and reviewed the grievance documentation. She explained that the patient and her family met with the Clinical Patient Relations Specialist on 8/26/11 and presented their concerns. The Clinical Specialist for the Office of Patient Experience stated the family requested the record be reviewed by an anesthesiologist. The family wanted an evaluation of the patient's symptoms, particularly regarding a new diagnosis of atrial fibrillation, and they wanted to know why the surgeon was not notified of the patient's readmission to the hospital. The Clinical Specialist for the Office of Patient Experience explained that the record was reviewed by the Medical Director of Anesthesia Associates, the Registered Nurse Director of the medical floor the patient was admitted to, medical staff services (for the peer review process), and the Operations Manager of Health Information Systems (to evaluate the process of notifying physicians of a patient's readmission). The final notice of response was sent to the complainant on 9/23/11.

The Coordinator of Quality and Patient Safety was interviewed on 3/23/12. She stated that Patient Safety services became involved in the investigation of the grievance on 9/30/11. She explained that additional physicians (from anesthesiologists to those involved in the Infection Prevention Committee) reviewed the record, including physicians outside of the hospital system. She stated every detail of the patient's care was reviewed, including all cardiac rhythm strips, ventilator settings during surgery, and the instruments used during surgery. She stated that based on the definition of the Centers for Disease Control guidelines, the pneumonia was classified as hospital acquired and was investigated through the infection control channel as per protocol. She stated one issue the complainant raised was related to the patient education material for the long term use of the anticoagulant Coumadin. She stated the video was viewed by two different staff members who felt the video was very direct but appropriate given the nature of the medication and the effect it has in the body.

The Coordinator for Quality and Patient Safety stated their department completed the investigation and met in person with the family on 10/19/11. According to the grievance documentation, the case was referred to Professional Relations because the patient and family were seeking financial compensation. The Coordinator for Quality and Patient Safety stated Professional Relations completed an additional review but also had access to the reviews from Patient Relations and Patient Safety services. She confirmed the Professional Relations review did not yield a new decision and was completed on 12/21/11 and a written notice was sent to the patient.

The Accreditation Manager was interviewed on 3/23/12. She was able to provide documentation that based on the diagnoses and events surrounding the above medical record, the record would have been funneled into the peer review process per hospital policy, because of the unplanned readmission within 14 days, and was not only reviewed as a result of the grievance.

The medical record for this patient was reviewed. The documentation from the outpatient surgery record, including documentation for the overnight observation, indicated the patient's symptoms were assessed and treated prior to discharge. The documentation for the re-admission indicated that both the patient's primary care provider, and the surgeon, were to be provided with a copy of the History & Physical, Consultation Report, and Discharge Summary.

Fourteen current patients were interviewed between 3/15/12 and 3/21/12. Each patient indicated they were aware of the process to voice a concern and felt comfortable addressing concerns with staff. None of the patients interviewed had any concerns that had not been addressed.

It could not be determined that the facility failed to thoroughly investigate and respond to grievances.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AMIEE HASTRITER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm